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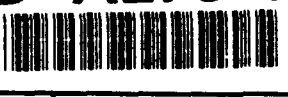

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Economic realities have aroused the American public. As national priorities evolve, healthcare is rising in prominence. The healthcare industry must now struggle with rapidly unfolding economic and social pressures. In response, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the United States Air Force (USAF) are changing their hospital accreditation and regulatory requirements.

This project evaluates Malcolm Grow USAF Medical Center's (MGMC) compliance with current and evolving JCAHO standards and USAF regulatory requirements regarding committee structure including the presence of specific committees, and the application of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) in committee structure operations. It also considers environmental adaptation in the recommendations.

A recent committee structure revision at MGMC reduced the number of committees from 42 to 30. This 29 percent reduction will go far to satisfy USAF inspectors seeking evidence of efficiency improvements. While the current committee structure satisfies many JCAHO and USAF requirements, TQM/CQI principles are not yet generally applied to committee structure operations.

The researcher recommends that a TQM process action team be chartered to review and evaluate the committee structure. To satisfy CQI requirements, an ongoing committee structure review and evaluation process using TQM/CQI principles should then be implemented.

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Malcolm Grow USAF Medical Center

Standing Committee Structure:

Accreditation and Governing Board Compliance

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U.S. Army-Baylor University Graduate Program

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ABSTRACT

Economic realities have aroused the American public. As national priorities evolve, healthcare is rising in prominence. The healthcare industry inc' 'ing the Military Health Services System (MHSS) is now struggling with unfolding economic and social pressures.

In reaction, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the United States Air Force (USAF) are changing their hospital accreditation and regulatory requirements. A trend is developing for simplification of inspection criteria and for more local control over facility operations. There is, however, a corresponding increase in the direct responsibility local managers bear for the activities of their hospitals.

This project evaluates MGMC's compliance with JCAHO and USAF requirements regarding committee structure including the presence of specific committees, and the application of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) in committee structure operations. It clarifies

requirements and considers the facility's changing operating environment in the recommendations.

The current committee structure satisfies many JCAHO and USAF requirements. The six committees required by JCAHO and USAF at present are: Governing Body, Infection Control, Executive Committee of the Medical Staff, Safety, Special Care, and Radiation Safety. A recent committee review resulted in a net reduction of 12 committees from the original 42. This 29 percent reduction will go far to satisfy USAF inspectors seeking evidence of efficiency improvements. However, TQM/CQI principles are not generally applied to committee structure operations.

The researcher recommends that a TQM process action team be chartered to review and evaluate the committee structure. To satisfy CQI requirements, an ongoing committee structure review and evaluation process using TQM/CQI principles should then be implemented.

INTRODUCTION

Conditions Which Prompted the Study

The MGMC Administrator was concerned about the facility's committee structure standing with evolving JCAHO accreditation standards and USAF regulatory requirements. A brief investigation confirmed the current committee structure, heavy with redundant or unnecessary committees, may not be in compliance. Further research of relevant references was required to define a standing committee structure which would comply with all current accreditation requirements, proactively adjust to evolving regulatory requirements, and effectively address the dynamics of the current changing operating environment.

Statement of the Management Problem (or Question)

Specific USAF and JCAHO standing committee requirements have changed, and new management philosophies such as TQM and CQI have been recently adopted by the Department of Defense (DoD). The facility's current committee structure as specified in MGMC Regulation 168-12, Center-level Committees, dated 11 September 1992 does not meet current accreditation

or regulatory requirements, does not provide for the evolving nature of the requirements, and does not accommodate timely environmental adaptation.

Review of the Literature

The literature search disclosed no previous studies or research regarding the committee structures of Air Force medical centers, or committee structures of medical centers generally. Accreditation manuals, regulatory publications and correspondence, interviews, textbooks, and reference books were the primary sources of information.

JCAHO publications and USAF regulations enumerated specific committee requirements, many of which are based on other government agency requirements such as the Occupational Safety and Health Administration (OSHA) and the Nuclear Regulatory Commission. The staffs at the Office of the Secretary of Defense (OSD), USAF/SG and AMC/SG provided various policy documents. AMC is MGMC's major command (MAJCOM) and is, therefore, an intermediate level command between the facility and HQ USAF; MGMC must answer to AMC directives as well as those from the Air Force.

The primary USAF regulation governing committee structure is Air Force Regulation (AFR) 168-4, Administration of Medical Activities, 1990. It was significantly changed in 1991 to reflect new JCAHO requirements. It also reflects a new USAF attitude toward simplification, efficiency, and enhanced local empowerment. This attitude is consistent with the required implementation of TQM/CQI in DoD.

The Secretary of Defense implemented TQM throughout the DoD via a memorandum (Carlucci, 1988). Since then, USAF organizations have been implementing TQM and applying its principles. For example, the Military Airlift Command (MAC), the previous name for MGMC's MAJCOM, developed a series of TQM training manuals to facilitate TQM implementation throughout the MAJCOM. Another effect of TQM implementation was an overhaul of the Air Force regulation system. OSD issued a memorandum which required enhancement of field-level autonomy over local operations (Cooke, 1992). In response, HQ USAF developed and is implementing a new "objective regulation" program (Pardini, 1992). Air Force Policy Directives (AFPD)

are to replace AFRs. AFPDs are to be short, about two pages long. They are to establish policy, but leave the "how to" execution of the policy up to local officials; local empowerment is the objective of the new system.

The USAF Inspector General (IG) also provided guidance. IG publications and an interview with G. W. Rake, a senior IG inspector, clarified Health Services Inspection (HSI) criteria. Regarding hospital committee structure, Rake said the IG is looking for efforts by the facility to eliminate redundancy and inefficiencies in meetings in order to minimize the time providers spend in meetings (personal communication, 5 January 1993). Reducing the number of committees in the structure, as a means of eliminating redundancy and inefficiency, is favorably regarded by the IG.

To see how MGMC compared to its peer facilities, the committee regulations of five other USAF medical centers were obtained and reviewed. USAF medical centers differ from other Air Force inpatient facilities in that the centers provide specialized

consultant support to all other medical facilities within a specified geographic area of responsibility. Even though the hospital at the USAF Academy is not a medical center and therefore not a similar facility, its committee regulation was also reviewed as it outlined a very "progressive" committee structure.

To balance the research, various textbooks and reference books were studied for theoretical insight. The referenced authors addressed management, environmental change and the impacts to the organization, committee operations including consensus management, and TQM/CQI implementation.

Peters (1992) noted that managers are fast disappearing, and workers are becoming managers. He said workers are to be trusted because they can handle most problems and should therefore be free to take risks. He believes management is in control only when they are "out of control," i.e., effective management empowers workers, not managers. There is evidence of support for Peters' beliefs in the Air Force. While TQM/CQI in the USAF is called "Quality Air Force," it is nevertheless empowering lower echelons of command on

down to the workers within each facility. One result is that rank or hierarchy disappears in TQM working groups at MGMC.

Levitt (1991) said organizations accomplish extraordinary things through routinization. He warns, however, that routinization is self-immolating as it deadens people's enthusiasm, attentiveness, and imagination. People become numb. To combat complacency, he recommends continuing education, and frequent reorganization and restructuring. To him, change is an ally. He said routines must be periodically sacrificed and healthy self-examination should be ongoing. Moderating his advocacy for change, however, Levitt said it's good to be skeptical of fashionable new prescriptions.

Indeed, a consistent topic of discussion throughout the literature was "change." While most authors considered change as inevitable, they stated that organizations and the people working within fear or at least avoid change. Many authors insisted the successful organization is one that can embrace change as a friend. Tucker (1991) said organizations must

ride the forces of change by trying to see patterns; leaders should embrace change, not fear it. Peters (1987) recommended a flat, functional organization emphasizing self-managed teams where information is shared by everyone. He said the organization's capacity to change is the most important corporate skill and that the capacity of individuals to accept disruption is fundamental to dealing with constant change. Concluding, he said "the self-managing team should become the basic organizational building block" (p. 297).

Some of the literature was specifically negative toward committees. Bird (1985) said committee members are often unable to agree and individually they are not responsible. He also said "one certain way of killing any good idea is to set up a committee to discuss it" (p. 98). Bird noted that referring an item to a committee is often a tactic used to prevent an idea from being taken further. It seems Bird may question the effectiveness of TQM consensus management for getting things done. Kriegel (1991) agreed. Noting that consensus management is usually accomplished by

committee, he said,

> Although consensus has a great deal of merit, it can also be a subconscious ruse for playing it safe, for no one taking responsibility. Seeking a win/win decision by consensus can result in compromise by identifying the lowest, rather than the highest, common denominator--a no-win for everyone. The hottest innovative idea can become lukewarm when watered down by every committee member and every possible consideration. (pp. 85-86)

Griffith (1992) provided various insights and considerations about committee structures specific to hospitals. He noted the most serious weakness of a committee structure was the time it takes to achieve a final action or decision. He said the real test for the structure is how quickly it can respond to new ideas.

Regarding the implementation of TQM/CQI, Executive Learning, Inc. (1993) said an organization is a system of interdependent parts which, in order to successfully

apply TQM/CQI, must align its processes, technology, people, values, and policies to support the effort to continually improve. This supports the notion running throughout all the literature regarding TQM/CQI: viz., its implementation must be an all-or-nothing affair.

Purpose

The purpose of this project was to evaluate the extent of MGMC's compliance with JCAHO and USAF committee structure requirements. The evaluation considered the presence of specific committees and the application of TQM/CQI in committee structure operations. It was also to clarify requirement trends and include recommendations to improve the structure's standing with developing requirements while considering the facility's unstable operating environment. The results of this project may then serve as a basis for revising MGMC Regulation 168-12, Center-Level Committees.

The basic assumption was that JCAHO accreditation standards, USAF regulations, and sanctioned management philosophies call for a revised MGMC standing committee structure. The variables included specific,

documented, requirements; and certain inferential elements based on trends and perceptions.

JCAHO references provided accreditation standards. USAF regulations, policies, and relevant governmental regulations specified current requirements and provided insight into their progression. Various TQM and CQI publications defined the associated management philosophy. Didactic material and reference books provided information about organization theory, committee operations, and boundary spanning. Valuable insight was gained by reviewing the committee structures of other Air Force medical centers and by contacting individuals who, either by position or by experience, provided useful information about future requirements and trends.

METHOD AND PROCEDURES

The project, broken down into sequential steps, involved objective data gathering and some subjective interpretation. The early steps gathered objective information which provided the basis for the later subjective or inferential steps. The steps were:

1. Determine specific JCAHO accreditation

requirements.

2. Develop inferred/future JCAHO accreditation requirements.

3. Determine specific regulatory requirements.

4. Develop inferred/future regulatory requirements.

5. Develop requirements based on Air Force management philosophy vis-a-vis TQM and CQI.

6. Develop considerations for a committee structure which provides for adaptation to a changing/turbulent operating environment.

7. Determine current committee structure.

8. Determine the committee structures of the other USAF medical centers.

9. Develop recommendations.

Perhaps the most critical aspect of the project was ensuring all current regulatory and accreditation requirements (steps 1 and 3) were clearly identified. These elements, if incomplete or erroneous, would likely result in recommendations leading to accreditation failure and/or regulatory noncompliance. The other elements (steps 2, 4, 5, 6, 7, and 8), while

providing a more complete and useful product, were not as critical in that, if erroneous, would not necessarily result in failure or noncompliance. Step 9 was based on the objective and subjective information taken from all the previous steps.

Information sources were varied. The medical center and base libraries provided general research material. MEDLINE was available at HQ USAF/SG, Bolling AFB. HQ USAF/SG provided useful information about current and future committee structure and management philosophy policies. AMC, located at Scott AFB, provided policy guidance. The base publications library furnished USAF regulations, and the OSD supplied copies of pertinent policy memorandums. There were many publications available within MGMC such as JCAHO manuals, inspection guides, TQM/CQI literature, USAF regulations, and MGMC regulations. Class notes from the U.S. Army-Baylor University Graduate Program In Health Care Administration augmented organization theory and behavior material. Interviews with staff members from USAF, AMC, IG, and MGMC were very helpful. Finally, the committee regulations of five other USAF

medical centers located at Lackland AFB, Wright-Patterson AFB, Scott AFB, Travis AFB, and Keesler AFB were obtained and reviewed. The committee regulation from the USAF Academy hospital was also obtained.

RESULTS AND DISCUSSION

A sequential objective-subjective stepwise process provided the logical research framework for the project. Objective data was determined first and provided the foundation for the subjective steps which followed. Final recommendations are addressed in the next chapter.

Specific JCAHO accreditation requirements

According to the JCAHO (1992), there are five required committees for a hospital: Governing Body, standard GB.1; Infection Control, standard IC.2; Executive Committee of the Medical Staff, standard MS.3.3.1; Safety, standard PL.1.4; and Special Care, standard SP.2.2. A Radiation Safety Committee is mentioned in standard DR.1.3.4 as not necessarily required for a hospital. According to Ratner, Chairperson, Department of Radiology at MGMC, it is required for MGMC because of the nuclear medicine

services available in the facility (personal communication, 16 March 1993). JCAHO, therefore, requires MGMC to have six committees.

A transition to standards which emphasize "continuous quality improvement" and "total quality improvement" are mentioned throughout the accreditation manual. Evaluation criteria for judging compliance with the standards include the role of leadership, function integration in processes, continuous improvement over time, and customer/supplier relationships. One implication is that the facility committee structure, one of the most fundamental structures for decision-making, should be a process selected for the primal application of TQM/CQI. JCAHO inspectors will be looking to apply their TQM/CQI evaluation criteria in reviewing the facility's committee structure.

Develop inferred/future JCAHO accreditation requirements

The JCAHO (1992) said the 1992 manual represents the first step in a major revision toward continuous quality improvement which will continue in the 1993 and

1994 editions. Further, the JCAHO (1992) said, "In 1994 and thereafter, standards that promote appropriate cross-departmental attention to quality will replace most of those that now refer only to departmental review" (p. xiv).

The 1993 manual reiterates the same specific committee requirements as does the 1992 manual. However, the standards for 1993 generally allow the organization even more flexibility by reducing the number and prescriptiveness of standards. In fact, hospitals are encouraged to discover their own problem-solving and monitoring processes. The 1993 manual notes future editions will place an increasing emphasis on cross-functional processes.

While the requirement for the basic six committees will continue, the JCAHO is setting a trend that will continue to provide hospitals with operational autonomy. Provided hospitals adopt a TQM/CQI orientation and sincerely implement the philosophy throughout, they can confidently pursue their own courses knowing they will satisfy TQM/CQI criteria in future accreditation surveys.

Specific USAF regulatory requirements

Headquarters USAF and AMC are the primary regulatory bodies for MGMC. AFR 168-4, Administration of Medical Activities (1990), states all USAF medical facilities must maintain current JCAHO standards. If there is conflict between Air Force policy and the JCAHO, Air Force policy will prevail. AFR 168-4 says JCAHO recognizes HQ USAF/SG as the governing body and "Federal law, Department of Defense and Air Force directives, Surgeon General policies, MAJCOM directives and policies, and local operating policies serve as the bylaws (p. 91).

Chapter three, section P of AFR 168-4 specifically list required committees. Interim Message Change (IMC) 91-1 (1991) to AFR 168-4 significantly revised those requirements from approximately 28 required committees to the same six that are now required by the JCAHO. Further, IMC 91-1 stated all previously required committees, other than the six required by JCAHO, may now be "functions" and their formation and operation are left to the discretion of lower level commanders and to the facility.

AMC, responding to IMC 91-1, said there is no absolute right or wrong facility committee structure. Easterling (1992), Chief, Quality Management for HQ AMC/SG said, "As long as you comply with JCAHO standards, you can add, eliminate, or restructure committees however best meets your individual facility's needs" (p. 1). She suggested using a redundancy test whereby committees may be eliminated or combined whenever the same data is being presented in both committees.

Further guidance was provided by the USAF IG which evaluates each facility for compliance with USAF regulations. The IG inspection guide (1992) now uses only broad TQM/CQI flavored criteria when evaluating a facility's committee structure. Examples of criteria include the structure providing effective oversight, the structure efficiently using members' time, and the structure allowing problems to be resolved at the lowest possible level.

Periodically, the IG publishes a summary of findings noted at facilities recently inspected. The 7 August 1992 issue stated a military treatment facility

was cited for a committee structure which had not yet been reorganized and which had 25 formal committees. Rake (personal communication, 5 January 1993), who wrote the citation, told me the IG was looking for each facility to design a structure which provides flexibility, eliminates duplication of effort, facilitates communications and decision-making, and minimizes the time, particularly unproductive time, members spend in committee meetings. Ideally, he said, there should be few formal oversight committees which manage many functions. In fact, he said, many committees currently in facilities should become functions. To determine oversight committees and their functions, he recommended the following procedure: (a) determine all functions; (b) classify functions as either "required," "necessary," or "unnecessary"; (c) logically group "required" functions together and "necessary" functions together; then (d) identify the oversight committee for each group. Each required or necessary function can then be "chartered" by its oversight committee.

The research did not find a specific definition of

a function. Based on many conversations and the inferences of the cited written material, a function is generally a process accomplished under conditions which are less formal and restrictive than a committee. Functions may not necessarily have to comply with the cumbersome, written regulations and policies which govern committee operations and administration.

The operation and administration of a function can be readily tailored to fit the circumstances for which it is formed. Its elements, such as meeting time, meeting frequency, documentation, or membership can be easily and quickly adjusted without having to go through the formal process required by a change to a facility regulation. A function, therefore, can more readily provide for increased efficiency and effectiveness of the membership's time and effort.

For example, function documentation is not limited to minutes as it is with a committee. A simple paragraph, a chart, a log, or even an oral report which is recorded in an oversight committee's minutes may document a function process. As circumstances change, e.g., a requirement to change the function's purpose, a

simple adjustment to the function's charter can be implemented without any formal authorization except perhaps by the oversight committee. However, since little specific accreditation or regulatory guidance is available for function operations and administration, caution must be exercised to ensure adequate documentation is available for inspectors.

Develop inferred/future USAF regulatory requirements

OSD issued a memorandum in 1992 which foretells the immediate future of USAF regulations. Cooke (1992) said the Secretaries of the armed services are directed to provide policy guidance, but "To the maximum extent possible, commanders, or other responsible officials in the field, should be provided the latitude to determine how a given policy is to be implemented at the local level" (p. 1). The memorandum continues, "Excessive constraints serve to thwart the application of on-site management expertise and to stifle individual initiative and creativity. Whenever possible, they should be eliminated from existing regulations and avoided in drafting new ones" (p. 1). The theme for the reorganization is centralized policy making and

decentralized policy execution.

In response to this and other OSD directives, HQ USAF established a Policy Review Tiger Team to study the Air Force regulatory situation and develop recommendations. As a result of Tiger Team recommendations, Pardini (1992) said Air Force Policy Directives (AFPD) or "objective regulations," augmented by a small number of Air Force Instructions (AFI) as required, will replace AFRs. AFPDs are to be brief, about two pages long. The MAJCOM may expound on the AFPD by issuing "how to" instructions. According to AMC (1993), the command will be totally converted to the new objective regulation system by 1 March 1994. AMC views the objective regulation program as an opportunity to simplify and clarify command policy and to empower local commanders to accomplish their mission.

The USAF IG supports the new objective regulation program and has adjusted inspection criteria accordingly. Current Health Services Inspection (HSI) guidance is much smaller and broader than previous guidance. This move toward simpler, broader inspection

criteria written with a TQM/CQI flair formally reinforces TQM/CQI implementation in the Air Force. It cements a new level of flexibility and empowerment that each facility will enjoy in controlling its operations.

The implications of the objective regulation initiative are far-reaching. Both HQ USAF and AMC intend to allow MGMC increased flexibility and control over its operations. Over the near future, MGMC will be encouraged to actively experiment with self-determination and take risks in order to increase operational efficiency and effectiveness, and to adjust to its own particular environment. In effect, the facility will be empowered as never before to take the initiative to design and operate its own committee structure with minimal guidance from its governing board. At the same time, just as local leadership assumes a greater role in self-determination, it also assumes more of the responsibility for the results of that leadership.

Develop USAF management requirements vis-a-vis TQM/CQI

The Secretary of Defense implemented TQM throughout DoD in 1988. TQM/CQI is not going away.

Words like "metrics, "process action teams," "empowerment," "quality improvement," and "facilitator" are common in daily communications at all levels and organizations in the Air Force, but even though the TQM/CQI element names may change in DoD, the fundamental principles are being disseminated and formalized. These same principles should now be applied to the operation of MGMC's committee structure.

To develop a TQM/CQI program at Malcolm Grow, the hospital's Executive Committee formed a Quality Council last year which reports directly to the Commander. A TQM office under the Directorate of Education and Training was established to implement and support the MGMC TQM/CQI program. Using a series of TQM courses developed by the MAJCOM, MGMC has been actively training assigned personnel. According to Pino (personal communication, 8 April 1993), head of the TQM office, nearly 80 percent of all assigned personnel have now received, as a minimum, a two day basic TQM course.

The researcher attended several of the TQM/CQI courses taught at Malcolm Grow including the "basic"

course and the "facilitator" course. At each course, a small booklet called The Memory Jogger, A Pocket Guide For Continuous Improvement was distributed to each person and it is made very clear that it is to be used at MGMC. The TQM office keeps a large supply on hand and intends to see each person assigned has their own personal copy.

It is understood by senior USAF leadership that implementation of TQM/CQI is a long-term project. USAF resources have been and will continue to be committed. The USAF objective regulations initiative, as an example, is consistent with and even promotes TQM/CQI as it allows local commanders maximum flexibility and control over their operations. By adopting and practicing the basic principles of TQM in developing new USAF regulations, the most fundamental building blocks of the entire organization, HQ USAF is establishing the modus-operandi for the future. The new, simplified IG HSI guidance is another example of the formalization of USAF TQM/CQI.

HQ USAF and lower echelon commanders will continue to emphasize empowerment of people at the lowest

levels. An increasing emphasis will be placed on local initiative. Cross-functional teams made up of process owners and workers is becoming the basic organizational problem-solving and process evaluation forum. Just as quality is now everyone's job, so ideally everyone will have the opportunity, even obligation, to speak up and get involved to improve their facility.

The committee structure at MGMC is as fundamental to the organization as the organization chart itself. It defines the facility's central decision-making process. The application of TQM/CQI to the evaluation and operation of such a fundamental structure as the committee structure is just what the Secretary of Defense had in mind when he implemented TQM/CQI. DoD and USAF inspectors will be pleased, and perhaps at this point in time, surprised with the application of TQM/CQI in MGMC committee structure operations; it demonstrates initiative and forethought. However, in a few months or perhaps a year or two, these same inspectors would be disappointed if no evidence of TQM/CQI application were to be found.

Considerations for adaptation to a changing environment

Change, both internal and external to MGMC, is permanent. However, the current pace and depth of change are perhaps the most profound in recent history. The driving forces behind these exceptional times are the new administration's health care reform initiative, the military draw-down, and the new JCAHO and Air Force TQM/CQI management initiatives. The consequences of change are unpredictable, but for a military medical facility such as MGMC, these times are particularly uncertain.

Fortunately, TQM/CQI embraces change. Various MAJCOM TQM instruction manuals (1991, 1992) promote the IDEA concept (Idea, Determine, Evaluate, and Act) as the structured approach to effect positive changes. The courses also teach the FOCUS-PDCA (Find, Organize, Clarify, Understand, Select-Plan, Do, Check, Act) methodology. Regardless of the method, in the constant search for reduced variation, TQM/CQI seeks new ideas and initiatives; new and varied perspectives about processes are the featured problem-solving resources. Anyone and everyone involved with the organization are asked to get involved. In a message placed in the

beginning of the basic TQM course, the MAJCOM Commander (1991) said, "As a command, we will not change as the result of an enormous program, but rather as the result of thousands of individuals and groups working together to solve small problems everywhere" (p. i). The course teaches that leaders are to provide staff with flexibility, workers are empowered to problem-solve and implement, and change is perceived as an opportunity.

The TQM organization is, therefore, inherently highly sensitive and responsive to changes in its internal and external environment. It is likely to have the information to appropriately respond and adapt. Each person involved with the organization is an empowered lookout or herald of change as individuals voice their perceptions and contribute new-found information. Groups are then formed to share information and implement adaptive initiatives. Thr›ugh aggressive information sharing, TQM facilitates boundary spanning, both internally and externally, and diminishes the negative effects of bounded rationality.

Organizationally speaking, TQM is a form of Contingency Theory. According to Brooke (1991),

Contingency Theory maintains there is no one best way to organize; it all depends on the situation at hand. At any particular point in time, the organization must fit the peculiarities of its external environment while accounting for its unique internal situation. Organizational flexibility is emphasized. The organization, at any given point in time, may be either organic with less formalization, rules, and constraints; or mechanistic with more formalization, rules, and constraints. Adjustment and adaptation is a continuing process of improving the organization's position or fit with its environment.

Winslow (1991) said change is normal, stability is abnormal; the best way to manage change is not to maintain stability; and people don't resist change, they resist the negative fantasies of punishment about change. He went on to say the best way to dispel negative fantasies is to give people information about how the change affects them and to get them involved in the change process. Concluding, he said people support what they help create.

JCAHO and OSD recognized the value of the

statistical tools, metrics, and management philosophies of TQM/CQI generally and implemented the principles to ultimately improve facility performance. But regardless of the requirement to comply with TQM/CQI inspection criteria, if applied to committee structure evaluation and operation at MGMC, TQM/CQI will help the facility deal with its particularly dynamic environment and the uncertainty associated with change.

People become empowered and involved in evaluating, on an ongoing basis, the effectiveness and efficiency of MGMC's decision-making process within the context of the current environment. Committees and functions may be added, deleted, or adjusted in response to cross-functional, open, non-threatening evaluations. Sensitivity to the environment is maximized as everyone in the facility becomes an environmental scout and has the opportunity to contribute and problem-solve. Facility responses to external uncertainty should become more proactive as changes are perceived earlier and more accurately. At the very least, the internal uncertainty Winslow spoke about is diminished.

The analysis and documentation of processes required by TQM/CQI facilitates the determination of patterns of change that Tucker (1991) talked about. Once change patterns are determined, organizations can adjust and adapt to patterns rather than seemingly random events, thus facilitating a more rational, logical, and effective approach to adaptation. TQM/CQI goes on to implement the worker empowerment, the self-managed teams, and the information sharing recommended by Peters (1987) as the organization proceeds with its adaptation to change.

At the same time, consensus management may not be appropriate in certain situations, particularly those that are time-sensitive. Griffith (1992) noted that the speed at which an organization responds to new ideas is a primary criterion for determining a successful organization. Environmental conditions may require team leaders and oversight committees to take control and expedite or even overrule natural TQM/CQI processes. And while the criticisms about consensus management noted by Bird and Kriegel are certainly valid, TQM does promote innovation and establishes a

positive, encouraging attitude toward change and risk-taking.

Determine current committee structure

A critical step was for the researcher to define the current committee structure. MGMC Regulation 168-12, Center-level Committees, dated 11 September 1992 was the starting point. There were some typographical errors, and the associated committee structure diagram was not consistent with the regulation narrative. There were also committee structure adjustments which were not reflected in either the regulation or the diagram.

The committee chairs and the senior executive staff were given the opportunity to adjust the structure diagram (add, delete, or combine committees) and update the narrative in the regulation. The committee structure diagram was corrected to match the current narrative in the regulation, and in February, the Executive Committee was briefed about updating the committee structure. Each committee fell within the areas of responsibility of one or more of the executive staff, and in fact, most of the committees were chaired

by one of them. Only a few committees were chaired by lower level staff. Each committee chair was to be a point of contact for that committee unless otherwise directed (see Figure 1). A special evaluation form was distributed, Figure 2, to each chair or point of contact to facilitate change inputs. All inputs were received by mid-March.

Additional pen and ink changes were added to the working committee structure diagram to reflect all the latest changes recommended by the committee chairs and points of contact. On 24 March, the updated diagram was distributed to the Executive Committee for their final consideration. One other recommendation was made and the working diagram updated again. A final pen and ink diagram was presented to the Executive Committee on 23 April. One other committee was deleted, and the diagram was approved. Figure 3 is the working committee structure diagram reflecting all the cumulative changes, and Figure 4 is a draft of the final committee structure.

Insert Figure 1 about here

Insert Figure 2 about here

Insert Figure 3 about here

Insert Figure 4 about here

Originally, there were 42 committees on the diagram. After the revision, there were 30 committees. Thirteen committees were deleted either through simple deletion, through recommendation that they be chartered via a separate MGMC regulation, or through incorporation into other committees; one new committee, the 10th Aeromedical Staging Flight (ASF) Administrative Council which was inadvertently missing from the original diagram, was added. This review resulted in a 29 percent reduction in the number of standing committees.

Committee structures of other USAF medical centers

It was useful to see how Malcolm Grow's "peers"

reacted to the new JCAHO standards and USAF requirements. According to AFR 26-2, Organization Policy and Guidance, (1982), a medical center differs from other inpatient facilities in that the center provides specialized consultant support to all other medical facilities within its geographic area of responsibility. The five other USAF medical centers studied are located at Keesler AFB, Lackland AFB, Scott AFB, Travis AFB, and Wright-Patterson AFB. The hospital at the Air Force Academy had totally overhauled their hospital committee structure, and while it was not a medical center, it was still beneficial to review their progressive committee structure.

The committee structure regulations were reviewed, particularly noting the number of committees in each structure. Table 1 summarizes the number of committees at each facility. They have all completed their committee structure reorganization and regulation revision with the exception of Scott AFB. At the time of writing, only a range in the number of committees at the Scott AFB medical center could be determined.

Excluding the USAF Academy, the number of committees at all the facilities vary between 21 and 42; the average is 33. Malcolm Grow's committee structure revision brings the total number of committees down from 42 to 30. The number of committees at MGMC is, therefore, consistent with the numbers of committees at its peer facilities.

Insert Table 1 about here

Table 1

Committees at USAF Medical Centers and the USAF Academy Hospital

Facility	Number of Committees
Keesler AFB	42
Lackland AFB (Wilford Hall)	38
Andrews AFB (Malcolm Grow)	30
Scott AFB	21-35
Travis AFB (David Grant)	26
USAF Academy	7
Wright-Patterson AFB	32

Conclusions and Recommendations

To satisfy current JCAHO and USAF committee structure requirements, MGMC must have at least six committees: Governing Body, Infection Control, Executive Committee of the Medical Staff, Safety, Special Care, and Radiation Safety. All six committees are active in Malcolm Grow's current committee structure. MGMC, therefore, complies with all current JCAHO accreditation and USAF standing, or permanent, committee requirements.

There is, however, pressure from HQ USAF and the IG to reduce the number of committees that are in excess of the six currently required by JCAHO. Facility committee structures are to be evaluated. Steps are to be taken to eliminate duplication of effort by committees, the time individuals spend in committee meetings is to be minimized, and committees are to be considered for possible merger into other committees, deletion, or reduction to a function. While not clearly defined anywhere in the literature, generally speaking, a function can fulfill the same purpose as a committee. The advantage of a function

over a committee is that the function is less constrained and formalized, thereby providing for great flexibility of process, operation, and administration, and for timely modification.

MGMC is in the process of reviewing its committee structure. The executive staff is reducing the number of committees from 42 to 30 committees; 13 of the structure's 42 committees are being deleted, and one additional committee is being added. This is a very positive step. MGMC's overhauled committee structure fares well compared to its peer facilities and it will go a long way to satisfy IG inspectors. However, the formal TQM/CQI committee structure evaluation process suggested by JCAHO and HQ USAF is not yet implemented.

It is true MGMC is actively implementing TQM/CQI generally, and inspectors should be pleased with the progress. A TQM office has been established and a Quality Council formed which has already sponsored several TQM process action teams. An ambitious TQM/CQI training program is in place to ensure 100 percent of all assigned personnel are trained; nearly 80 percent have in fact been trained since the training program's

implementation last year. The Administrator has even used the TQM process in evaluating committees within his area of responsibility, but no facility-wide application has occurred or is being planned.

A TQM process action team (PAT) that is chartered to evaluate MGMC's committee structure would be appropriate. Committee structure evaluation lends itself to the application of TQM/CQI. Besides satisfying JCAHO and USAF requirements for applying TQM/CQI principles generally, I believe the TQM/CQI methodology will produce the best possible solution. A special TQM PAT can be chartered by the Quality Council to evaluate each committee's purpose, membership, meeting frequency, and documentation administration.

The PAT, formed and operated in accordance with TQM/CQI principles, would include team members who, having diverse backgrounds, would have a fresh outlook and be encouraged to contribute. Representatives of the committee currently under review may also be members while their committee is being evaluated. The PAT would methodically study each committee to determine whether it should be modified, merged, or

eliminated. Perhaps some committees would operate better as functions with less documentation requirements and less formalization. The methodology recommended by Rake would be helpful in sorting out the various functions and committees.

Besides the committee-by-committee evaluation, one of the first problems to address involves proper documentation. I am concerned with the lack of specific guidance from JCAHO, HQ USAF, and the IG regarding documentation requirements. As committees are deleted or reduced to functions, what forms of documentation may, in the inspector's eyes, replace minutes? AMC provided some guidance, but the actual accrediting and inspecting agencies remain purposefully vague. A systematic, common-sense approach to function documentation makes sense and can be easily defended. However, until the actual inspection, a degree of uncertainty will remain.

Great care must be taken throughout the evaluation. Griffith (1992) notes the committees that exist and who is on them is a key source of influence. He emphasizes that the principal problem in designing a

committee structure is deciding how to bring activities together to form decision-making groups which are effective in both size and representation. TQM/CQI principles, when applied to the committee structure evaluation at MGMC, could answer Griffith's concerns.

TQM/CQI could also help the assigned personnel at MGMC cope with the dynamics surrounding their facility. As Griffith (1992) says, a hospital must respond to its changing environment, and much of that response should be initiated from within. Winslow's (1991) point about involving people in the change process to dispel their fears is most applicable. They become creative and contribute to the development and implementation of organizational adjustments. As people support what they help create, adjustments to the committee structure would not be threatening.

The concerns of Bird (1985) and Kriegel (1991) about the consensus management orientation associated with a committee are valid. Gridlock, endless discussion, and the dilution of innovation may neutralize the effectiveness of TQM teams. Team leaders and senior staff must be wary and stand ready

to adjust and direct the TQM process if conditions warrant. They must be aware, however, that frequent violations of the TQM process, if not handled properly, will create suspicion and frustration. I believe that, given the opportunity and information to completely understand the situation, team members will generally accep[illegible]e necessity for these overriding actions.

A[illegible]er the initial evaluation is completed, I recommend implementation of a system which provides for ongoing committee structure evaluation. Perhaps the original PAT can be reformed periodically, annually for example, to review each committee's operations over the past year. Another system may require each committee chair to periodically review their committee's performance and report to the Quality Council or their respective oversight committee to propose adjustments. The important point to remember is the facility committee structure must be continually improved and/or adjusted to fit MGMC's evolving environment. This process should also combat the numbing routinization mentioned by Levitt (1991).

As the committee structure is reviewed, evaluated,

and adjusted, the governing board's vision and MGMC's mission must remain predominant because the organization's purpose and direction ultimately serve as the guiding banners for all facility activities and processes. I recall a relevant World War II story once told to me while on a visit to the Philippines. As the Japanese settled into their newly won positions throughout the Philippine Islands, the victorious senior officers became dismayed with their overconfident troops. The men were becoming lazy, sloppy, and preoccupied with the various diversions available to a conquering army. In desperation, the senior officers had the following words posted prominently on all the bases and in all the buildings: "DON'T FORGET WHAT WE CAME HERE FOR." The simple genius of the words struck home and stimulated great reflection among the troops. The Japanese eventually lost the Philippines, but history confirms it wasn't for lack of purpose, discipline, or determination. Just as the Japanese remembered their purpose, so the hospital staff involved with committee reviews and evaluations must remember why they are there: to ensure

the committee structure at least sustains and preferably advances the hospital's vision and mission.

I recommend MGMC ultimately move toward a structure based on cross-functional teams, or functions, chartered by a relatively small number of standing oversight committees. These teams, which may be temporary, are formed to problem-solve, gather information, or perform functions and processes. The oversight committees, constantly seeking to improve processes, can readily adjust the operation and administration of their functions as circumstances change.

For example, since the Cancer Control Committee is not specifically required by JCAHO or HQ USAF, it could be reclassified as a function under the charter of an oversight committee which in this case is the Executive Committee of the Medical Staff (ECOMS). This would not only reduce the number of committees in the structure, but more importantly, it would afford great flexibility in the operation and administration of the cancer control function. Its original charter, and any subsequent adjustments, would be approved by the ECOMS

without concern for the requirements involved with changing the medical center committee regulation. It could be structured to operate like a committee, a TQM team, a working group, or even a loose collection of individuals primarily working independently; it all depends on what works best under the given circumstances.

Elements within a function such as membership, responsibilities, documentation, or meeting schedule can also be readily adjusted to more efficiently and effectively meet the particular requirements and constraints of the situation. For example, documentation is not limited to the minutes format stipulated in USAF, MAJCOM, or medical center regulations. Perhaps paragraph minutes format, charts, or even a simple diary may suffice. Regardless of the documentation format, the determination is made locally at the function level, or at most, the oversight committee level thereby supporting HQ USAF "empowerment" philosophies. I must, however, reiterate the current state of uncertainty surrounding accreditation and regulatory requirements for function

documentation.

Functions, working groups, TQM teams, and oversight committees will have to remain sensitive to imposing internal and external time constraints while seeking to adapt and adjust. Ideal procedures and processes may have to be compromised in the interest of taking timely actions. A long-term perspective is required to understand that, eventually, the net contribution to the hospital will exceed the immediate costs in terms of time and effort. JCAHO, DoD, HQ USAF, the IG, and HQ AMC have not only endorsed, but mandated the implementation of TQM/CQI. I believe MGMC will be safe from criticism by practicing these very same management principles.

There are many opportunities for further and continuing research. As new JCAHO manuals and USAF objective regulations are distributed, new documentation and committee structure requirements may emerge. JCAHO and HQ USAF documentation requirements, particularly for functions, should be clarified through additional, ongoing investigation. Further investigation into exactly how CQI is to be applied to

committee structure operations is required. As the nation's new health care policy unfolds, accreditation and regulatory requirements may be altered. Certainly MGMC's operating environment, driven by the dynamics of evolving national priorities, will continue to change and impose new realities for the committee structure. Finally, for all the obvious reasons, prudent managers will want to keep pace with this dynamic accrediting and regulatory environment.

Malcolm Grow has the marching orders, or opportunity, to adjust its committee structure and improve its fit with its own particular situation. Indications are that local empowerment is here to stay for years to come. TQM/CQI principles, oriented toward people empowerment and continuous organizational adjustment, are the sanctioned guides which are to lead the facility through these uncertain and tumultuous times. The principles emphasize environmental sensitivity and provide for flexibility of response in the constant search for improvement in the face of changing conditions. I believe the staff at MGMC, providing they never lose sight of their facility's

vision and mission and apply TQM/CQI principles in the design and operation of the committee structure, will not only satisfy current and future JCAHO and USAF inspectors, but they will also mold the most satisfactory committee structure possible given the circumstances present at any particular moment during these uncertain times.

In summary, I have researched various committee structure accreditation and regulatory requirements and have made recommendations which will ensure MGMC's continued compliance. The recommendations incorporate the new management philosophies adopted by HQ USAF and considered the medical center's changing environment. The project will be available to the MGMC staff for their consideration when revising MGMC Regulation 168-12, Center-level Committees.

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MGMC COMMITTEES, BOARDS, AND COUNCILS 5 JAN 93

IAW

MGUSAFMC Regulation 168-12, 11 September 1992

COMMITTEE	SG	SGH	SGA	SGD	SGE	SGP	SGN	DET 1	OTHER
Executive	⊗	X	X	X	X	X	X	X	
Bio Med Ethics		⊗	X		X		X		
Cancer Control		⊗	X						
Credentials Rev		⊗		X			X	X	
Critical Care									MED DIR ICU
Health Care Rcds		⊗				X	X	X	
ECOMS		⊗	X	X		X	X	X	
Instit Rev		⊗			X		X		
P & T		⊗		X			X		
Rabies Advisory						⊗			
Radiation Safety			⊗				X		
FUB		X	⊗	X			X		
Surg Case Rev		⊗							
Tumor Board		⊗				X			
Aero Med Coun	X	X				⊗		X	
Family Advocacy		⊗							
Cost Cent Man									DIR RES MGMT
DEERS Work Gp									DIR PAT Admn
ERAA		X	⊗	X	X	X	X	X	
FMB		X	⊗	X	X	X	X	X	
HAMS Contract			⊗						
Hth Con Adv Coun	⊗	X	X	X			X		
Hlth Promotions									HTH PROM COORD
Int/Res Stff Asc									PRES, HOUSE STAFF
Infection Control			X	X			X	X	Chair, Dep MED

X = member

○ = CHAIRPERSON

POC = Point of Contact IF other Than Chairperson

Figure 1. Committee Chairpersons/Points of Contact

COMMITTEE	SG	SGH	SGA	SGD	SGE	SGP	SGN	DET 1	OTHER
Medical Lib		X	X	X	⊗	X	X		
Med Readiness	⊗	X	X	X	X	X	X	X	
Prod Std and Rev									DIR, MED LOG
Safety/Res Prot		X	⊗	X		X	X		
Sensitive Dut									DIR, PAT Adm
Energy Conser			⊗						
Prof Education		X			⊗				
Dental Educat				X					DIR, GEN PRAC RESID
Resident Coord					⊗				
Quality Council	⊗	X	X	X	X	X	X		
Dent Svcs Mgmt				⊗					
Dent Prof Staff				⊗					
Dental QA/RM				POC					D. QA/RM COORD
Dent Rcds Mgmt				POC					NCOIC D. RCDS
Dental Health				POC					D. HLTH OFFICER
Nursing Exec							⊗		
Admin QA/RM									A. QA/RM COORD

5 Jan 93

MGMC Reg 168-12 "COMMITTEE" EVALUATION FORM

NAME OF "COMMITTEE": _____

P O C: _____, **OFF SYMBOL** _____, **EXT** _____

The information provided by you on this form will be used to develop improvements to MGMC Regulation 168-12, Center-level Committees, dated 11 Sep 92. Please review the portion of the regulation that describes this "committee" (page _____) and note any errors and/or recommended changes on the form. The chairperson should complete the form, but fellow committee members should have the opportunity to contribute (i.e. complete the form during a committee meeting if possible). Please return the form to **Capt James Cohen, SGA-AR, ext 4416 by** _____ **(please call if you need further clarification, due-date extension, etc..** Thank you for helping.

COMMENTS/RECOMMENDED CHANGES

COMMITTEE TITLE:

AUTHORITY/REFERENCES:

FUNCTIONS/CHARTER (PURPOSE):

COMPOSITION/MEMBERSHIP:

MEETINGS (FREQUENCY):

MINUTES (DOCUMENTATION, WHERE FILED):

ACCOUNTABILITY/REVIEWING AUTHORITY:

OTHER:

Figure 2. Committee Evaluation Form

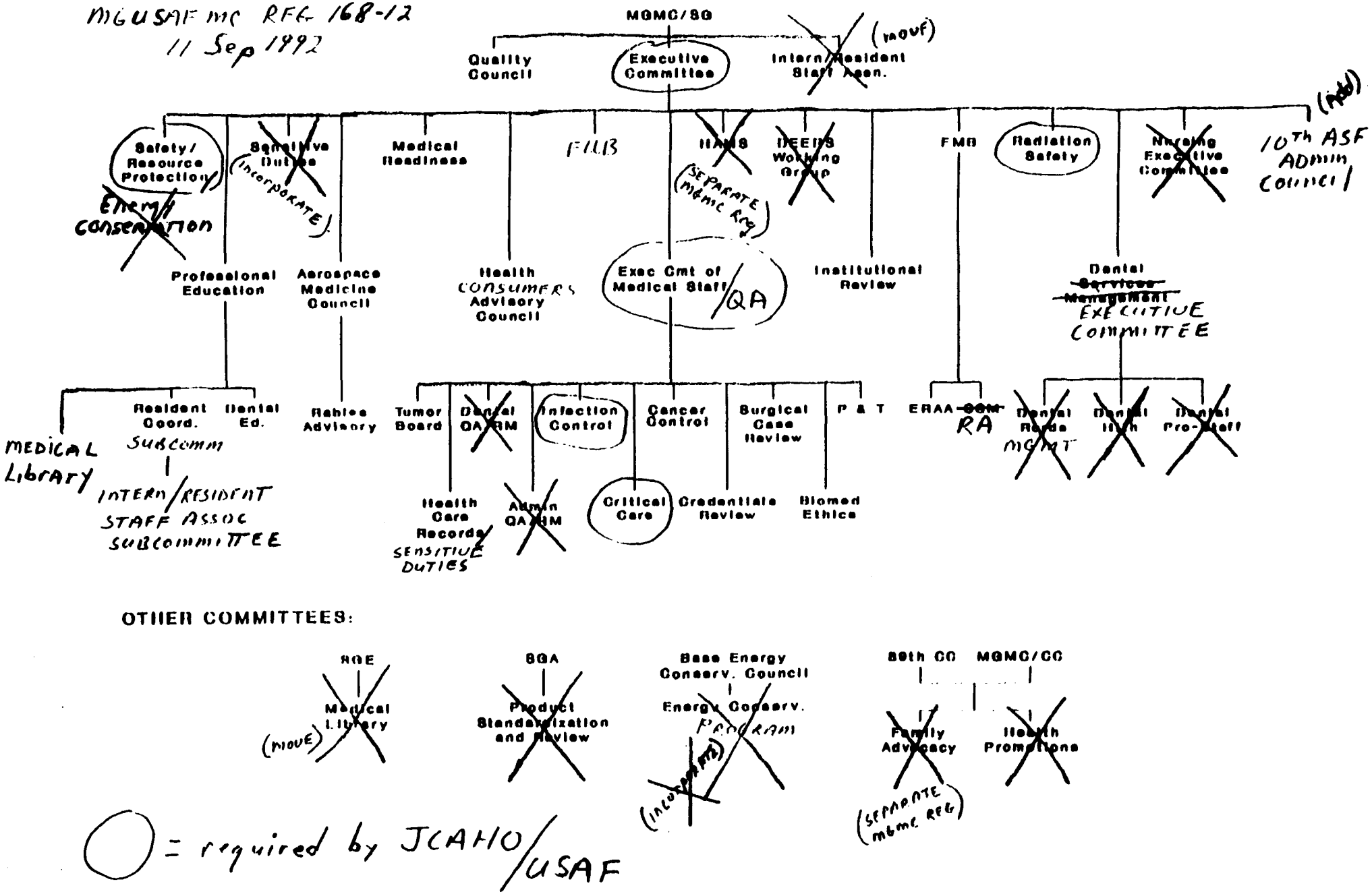
Working

Changes

4/23/93

COMMITTEE STRUCTURE

MGUSAFMC RFC 168-12
11 Sep 1992



OTHER COMMITTEES:

○ = required by JCAHO/USAF

Figure 3. Working Committee Structure Diagram

COMMITTEE STRUCTURE

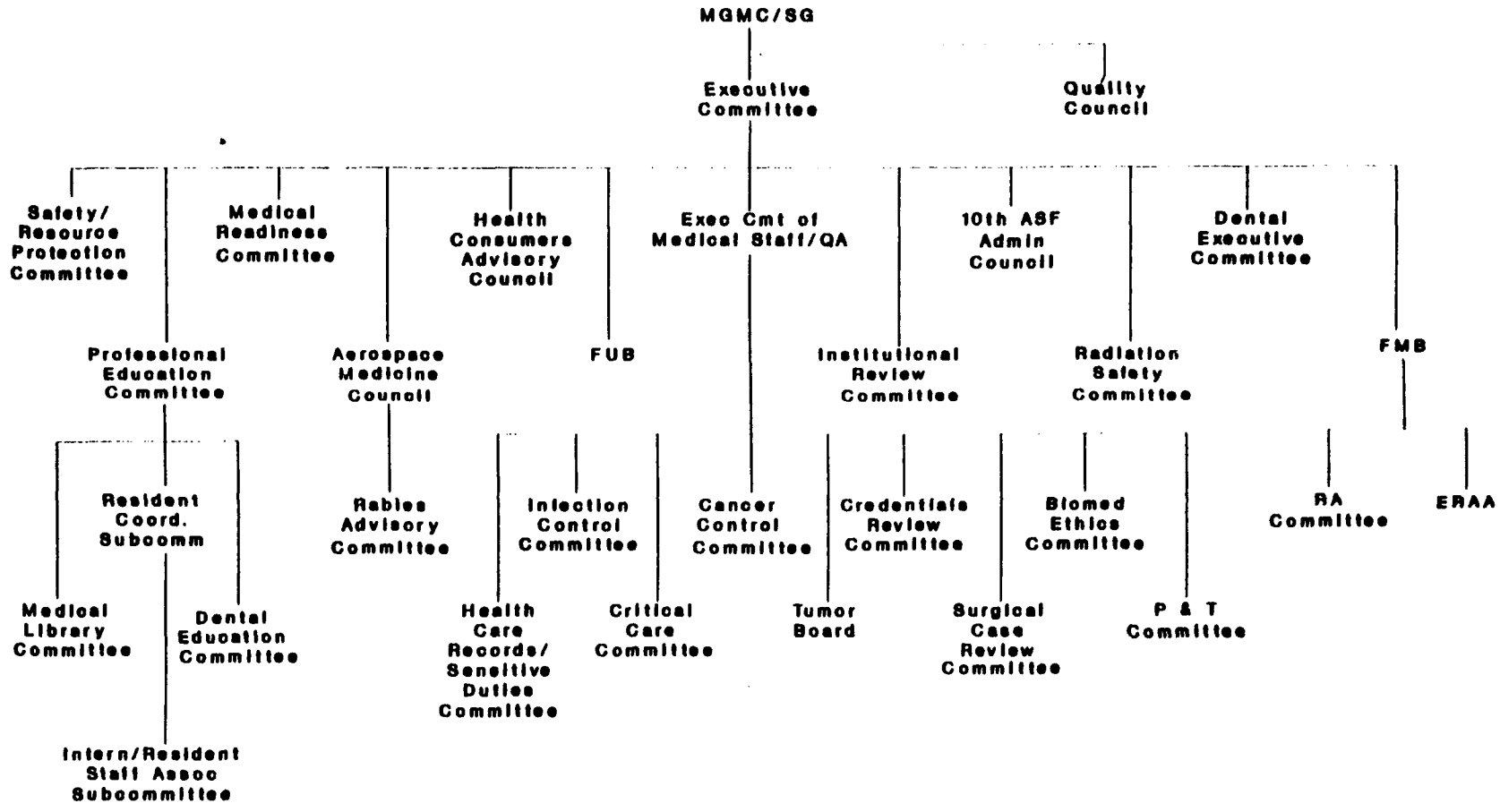


Figure 4. Draft of Final Committee Structure Diagram